

Attitudes Toward Medicare Among Older People

RODNEY M. COE, Ph.D.

THIS is a report of some followup data on the response to Medicare by residents of five Midwestern communities. In an earlier paper (1) results of a survey of older residents in the same communities were reported in terms of their awareness of and knowledge about Medicare and, of course, of their attitudes toward the program which was just getting underway.

Data from the 1966 survey indicated that almost all respondents had heard of the program, and while knowledge of specific details about the program varied, 70 percent of the respondents held favorable attitudes toward the program. Thus, as an innovation in philosophy and method of payment for medical care services, Medicare had initially received a positive evaluation and widespread acceptance. Most studies of innovation, however, suggest that subsequent reassessment of the innovation is important to obtain a more stable measure of its acceptance (2).

Dr. Coe is associate professor of community medicine, St. Louis University School of Medicine, and director, Medical Care Research Center, St. Louis. Other members of the research team are Jack Sigler and Warren A. Peterson, Institute for Community Studies, Kansas City, Mo.; Eugene A. Friedmann, Kansas State University, Manhattan; Harold Saunders, University of Iowa, Iowa City; and Douglas Marshall, University of Wisconsin, Madison.

The project was financed by Public Health Service grant CD-00244 to the Midwest Council for Social Research on Aging.

The data reported in this paper were derived from a 1968 survey of older residents in the same communities. Although a new sample of residents was drawn (that is, this is not a panel study), the criteria for selecting respondents and the geographic areas from which the sample was drawn remained the same as for the first survey (1). Thus, the five communities included one metropolitan area, two cities with populations of 100,000, and two smaller communities in counties with populations of about 30,000.

Within each of these areas we drew a probability sample of households with at least one person aged 60 or older who consented to be interviewed. The distribution of respondents in the new sample differed less than 1 percent from the distributions in the first sample on the characteristics of age, sex, and race. Therefore, on these dimensions, the two samples may be considered as having been drawn from the same population.

Expressed Attitudes Toward Medicare

Inasmuch as nearly all respondents in the first survey were aware of Medicare and their factual knowledge about it had little to do with their attitudes toward it, this line of inquiry was not repeated in the second survey. However, the general question, "Do you think Medicare is a good idea?" was asked again.

The data in table 1 indicate a significant trend in increased approval of Medicare. In every community the proportion of respondents who believed that Medicare is a good idea increased,

while the proportion opposed to it declined to only 3 percent. Furthermore, we found that the increased approval of Medicare was greater among women than men, among persons eligible for the program than those who were younger, and for persons with inadequate incomes than those who were more comfortably situated.

In 1968 fewer people were unable to report some opinion about the program. A high percentage of "don't know" responses could be expected in the initial survey, but after the program had been operating 2 years, few respondents had not formed some opinion of it.

Besides the magnitude and direction of change in attitude, we were, of course, also interested in the reasons for any observed change. In this case, the question was "Why do you think it (is or isn't) a good idea?"

It should be recalled that in the first survey the principal reasons in favor of Medicare were "It provides care for those who need it" (41 percent), and secondly, "It provides money to pay medical bills" (30 percent). In the second survey, these same two responses were most frequently given, but in reverse order. That is, most respondents said that Medicare provides "money to pay medical bills" (52 percent) and secondly, it "provides care for those who need it" (44 percent).

Table 1. Percentage¹ of responses to "Do you think Medicare is a good idea?"

Community and year	Yes	No	Not sure	Number of responses
All communities:				
1966-----	69	8	22	2,599
1968-----	87	3	11	2,090
Metropolis:				
1966-----	73	7	19	863
1968-----	88	3	9	705
Ozark City:				
1966-----	67	10	23	566
1968-----	90	3	7	455
Center City:				
1966-----	69	10	21	520
1968-----	85	3	12	474
Prairietown:				
1966-----	70	8	22	370
1968-----	87	3	10	239
Watertown:				
1966-----	67	8	25	280
1968-----	83	2	15	217

¹ Totals may be less than or exceed 100 by not more than 1 because of rounding.

Much less often cited was a third reason, Medicare "provides access to a hospital when necessary" (8 percent in 1966, 11 percent in 1968). Some of the other reasons for a favorable attitude toward Medicare included "I just think it is a good idea" (6 percent), "It provides reasonable protection" (5 percent), and "It supplements other coverages" (3 percent).

Although the percentage of respondents opposed to Medicare declined in the second survey and, therefore, we are considering only 56 people, there is an important change in the reasons why they object to Medicare. In 1966 respondents cited reasons reflecting a concern for proper use of facilities and the quality of the program. In addition there were ideologically based responses, such as "loss of independence" or "unfair burden on the young."

In the 1968 survey the principal reasons given again concerned use and quality of the program, but a much larger proportion stated that they "can't afford the deductions" (16 percent in 1966, 26 percent in 1968). Some people eligible for Medicare still perceived financial barriers to obtaining health care services, and these barriers were reflected in expressed attitudes toward the program.

Other Perceived Effects of Medicare

In addition to assessing changes in attitude toward Medicare as a program, we were interested in learning whether these respondents had perceived other kinds of changes in their lives as a consequence of Medicare. Particularly we were interested in changes in relationships with their families (especially their adult children) and with their physicians and in their general sense of well-being.

Theoretically at least, a program to provide health services to older people could influence the relationships of the older people to their children insofar as the aged are able to obtain help for illnesses and disabilities which might otherwise make them dependent upon their children. At the same time, Medicare has the potential to alter an older patient's relationship with his therapist. That is, removal of a part of the financial barrier to health care should encourage older patients to seek care more regularly, if not always more frequently,

thus reducing the potential for a long, costly period of intensive medical care and maximizing the possibilities for maintaining relatively good health.

There is some evidence that some physicians have already begun adapting their practices to the new demands of the concept of health maintenance, including more frequent contact with patients and more extensive use of preventive medicine techniques (3). Moreover, the removal of worry about paying for medical care in the event of serious illness (to the extent that Medicare actually achieves this) ought to be reflected in a general feeling of well-being on the part of older residents.

To tap these dimensions in the 1968 survey, we asked the questions more or less directly. For example, one question was "Has Medicare in any way changed your relationship with your children or other members of your family?" The response was uniformly "No." All but one or two of the more than 2,000 respondents said that Medicare had not in any way altered their relationship with their families.

Similarly, we asked, "Has Medicare in any way changed your relationship with your doctor?" Again, the response was almost unanimously (99 percent) "No." These respondents had perceived no change at all with respect to their physicians.

Finally, we asked, "Has Medicare in any way changed your sense of security about the future?" About half the respondents replied "Yes." Medicare had changed their sense of

security about the future, and almost all of them (98 percent) said that they felt more secure than before the program started.

To pursue this line of inquiry a little further, we asked why they felt more secure as a result of Medicare. The responses were very much like those reported previously in regard to positive attitudes toward Medicare. That is, about one-third of these respondents (those who felt more secure) indicated that the reason was because Medicare "paid the medical bills" (32 percent) and it "assures care if you need it" (27 percent) and, in the same vein, "Medicare provides financial help" (21 percent). These responses were not much affected by any of the independent variables being used in this study, for example, age, sex, social class, health status, or adequacy of income.

Experience With Medicare

In addition to data on attitudes and perceptions of Medicare, we wished to know to what degree the respondents had used the program to pay for some or all of the medical care services which they had received. Thus, one question asked in both surveys was ". . . have you had any part of your doctor or hospital bills paid for by Medicare, either directly to you or to the doctor or hospital?"

The results shown in table 2 indicate a significant increase in use of the program to pay for health care services. Not only did the percentage of respondents using Medicare increase from less than 10 percent to almost 25 percent, but it seemed that persons in the poorest health (therefore those needing the most services) made proportionately greater use of the program. Also, those with only an adequate financial status benefited most.

It should be noted, however, that the results represent a change only in degree to which all groups benefited, not a change in relative order. That is, data from both surveys indicate that a larger percentage of persons in the poorest health and with the least adequate income received benefits from the Medicare program than persons in other categories. On the second survey, the same relative standings persisted, but all of the standings were at a higher level. At the same time, the percentage increase in pro-

Table 2. Percentage of respondents using Medicare, by perceived health and income status

Status	1966	1968
Total using Medicare.....	19	24
Health.....	(¹)	(⁴)
Very good.....	5	15
Good.....	7	18
Fair.....	13	31
Poor.....	19	39
Income.....	(²)	(³)
Comfortable.....	8	21
Adequate.....	9	26
Inadequate.....	16	29

¹ N=2,599. ² N=2,090. ³ N=178. ⁴ N=490.

portion of respondents using Medicare was greatest for those in very good health and those with adequate or comfortable incomes.

The other question regarding experience with Medicare was whether the respondent had experienced any problems in getting bills paid by the program. There has been much discussion in the literature concerning the potential problems of administering such a large program (4, 5). As one indicator of acceptance of an innovation, it could be expected that the frequency of reported problems would decline over time.

For these samples of older respondents who had had some bills paid by Medicare, the percentage of persons reporting problems did decline from 35 percent in 1966 to 21 percent in 1968. Actually, the majority in both surveys reported "no problems" in getting their bills paid (65 percent in 1966, 83 percent in 1968). Where problems were perceived, the most common one was "delay in reimbursement" which was mentioned by 14 percent of the 178 respondents who had used Medicare in 1966 and by 11 percent of the 490 users of Medicare in 1968.

The only other major complaint about getting bills paid was "lack of communication." That is, in the 1966 survey, 12 percent of the users of Medicare stated that they did not really understand the program and that they could not always get information from the physician's office. By the 1968 survey, however, this complaint had declined to 2 percent. In terms of viewing Medicare as an innovation, this is a significant aspect of the acceptance of the program.

Conclusions

The overall change in the 2 years since the first survey has been a significant increase in the approval and acceptance of Medicare as an innovation in philosophy and method of paying for health care services. The measurement of this change has been relatively simple and straightforward.

More difficult, however, is the assessment of the sources of change. That is, the degree of increase in approval seems to cut across size of community, and this approval is not always consistently related to such usually influential characteristics as economic status or perceived health status.

It would seem, rather, that the increase in approval is highly affected by the realization that medical bills are paid by the program, even though not always in the full amount. This interpretation stems from the increased salience of the reasons for approval of the program; the reasons are almost all related in some degree to the financial aspects of obtaining medical care. This realization would seem to be more significant for this age group inasmuch as disproportionate numbers of older persons have inadequate incomes.

Perhaps a second reason for the increased approval is that the program does work despite the potential difficulties that were predicted for it. To be sure, many significant problems may remain, and on an individual level many respondents in this survey may have experienced some difficulties with the program. If so, difficulties are much less often reported as problems (and presumably less often perceived as problems) by these respondents. Thus when more than eight of 10 respondents claim there has been no problem in getting their medical bills paid, the program must be judged a success.

The evaluation of an innovation, of course, involves many different criteria, and this paper has dealt with only one, namely, the degree to which the innovation has been approved by the population it is supposed to benefit. Other dimensions of Medicare as an innovation remain to be studied, and much work remains to be done before an evaluation of the Medicare program is completed.

Summary

Comparison of the attitudes of older residents of five Midwestern communities in 1968 with those manifested in 1966 showed that approval of Medicare had increased. The sample in both surveys was drawn from the same population, and the distributions in the second sample differed less than 1 percent in the characteristics of age, sex, and race.

Sixty-nine percent of all respondents approved of Medicare in 1966, and 87 percent approved in 1968; 8 percent disapproved in 1966, but only 3 percent disapproved in 1968. The increased approval was greater among women than men, among persons eligible for Medicare than those who were younger, and among per-

sons with adequate income than those who were comfortably situated.

Of the respondents who approved in 1966, 41 percent did so because Medicare "provides care for those who need it," and 30 percent approved because it "provides money to pay medical bills." In 1968 the same responses were given in reverse order by 52 percent and 44 percent, respectively. Sixteen percent of the respondents said they could not afford the deductions in 1966; 26 percent made the same statement in 1968.

All except one or two of the more than 2,000 respondents said Medicare had not altered their relations with members of their families, and 99 percent perceived no change with respect to their physicians. Half of the respondents said they had perceived a change, and 98 percent of these persons said they felt more secure since Medicare began.

Less than 10 percent of the respondents had used Medicare in 1966, but in 1968 nearly 25 percent had benefited. Data in both surveys showed that persons in the poorest health and those with least adequate financial status benefited most.

In 1966, 65 percent of the respondents reported "no problems" getting their bills paid, but this response rose to 83 percent in 1968. Delay in reimbursement was mentioned by 14 percent of the users of Medicare in 1966, but by only 11 percent in 1968. Those who did not understand the program dropped from 12 percent in 1966 to 2 percent in 1968. The increase in approval of Medicare is the result of the realization that medical bills are paid by Medicare even though not in the full amount.

REFERENCES

- (1) Coe, R. M., et al.: Response to Medicare. Public Health Rep 83: 271-276, April 1968.
- (2) Rogers, E. M.: Diffusion of innovations. The Free Press of Glencoe, New York, 1962.
- (3) Coe, R. M.: Physicians' attitudes toward preventive health care services. Medical Care Research Center, St. Louis, 1968.
- (4) Feingold, E.: Medicare: Policy and politics. Chandler Publishing Company, San Francisco, 1966.
- (5) Somers, H. M., and Somers, A. R.: Medicare and the hospitals. The Brookings Institution, Washington, D.C., 1966.

Tearsheet Requests

Dr. Rodney M. Coe, 216 South Kingshighway, St. Louis, Mo. 63110

Regulation for X-ray Emission Levels

A regulation has been set for maximum X-ray emission levels for certain electronic tubes used in high school and junior college science classes which limits X-radiation from the tubes to levels which will keep exposures below the maximum recommended by the National Council on Radiation Protection and Measurements for students under 18 years of age. The regulation applies to manufacturers of the tubes as a radiation performance standard under the Radiation Control for Health and Safety Act.

One type of tube is used to demonstrate the phenomenon of X-rays. The other is used to demonstrate certain scientific principles, such as the ability of electrons to produce heat and is not intended to emit X-rays.

The standard was developed by the Bureau of Radiological Health, Department of Health, Education, and Welfare. It requires that X-ray exposure rates from the tubes not exceed 10

milliroentgens per hour at 30 centimeters (about 1 foot) from any surface or enclosure of two types of cold-cathode tubes used in science classes.

In a survey of electronic equipment used in science instruction, conducted by State-Federal authorities, both types of tubes were found to create X-ray exposure problems for students and teachers. The survey was conducted in 181 high schools across the country, and State health authorities found similar tubes in junior colleges.

Cold-cathode X-ray tubes would be required by the standard to be shielded in a manner to confine X-rays to a specified area. Many unshielded X-ray tubes were found by the State-Federal survey. Some tubes could emit X-rays in all directions at rates many times the recommended maximum.